STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		С	
		005051	B. WING		1	, 4/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
INDIANA U	JNIVERSITY HEALTH		NATE BLVD			
	OLIMAN DV OT		OLIS, IN 46202			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS		S 000			
	This visit was for the complaint.	investigation of one (1) State				
	Complaint Number: IN00161373 Substa related to allegation of	ntiated; State deficiency ited				
	Date of survey: 02/2	3/15 through 02/24/15				
	Facility number: 0	05051				
	Surveyor:					
	Jennifer Hembree RN Public Health Nurse S					
	rubiic Health Nuise C	bulveyor				
	QA: claughlin 02/26/	15				
S 926	410 IAC 15-1.5-6 NU	RSING SERVICE	S 926			
	410 IAC 15-1.5-6 (b)(1)				
	(b) The nursing service following:	ce shall have the				
	(1) Adequate number registered nurses, lice nurses, and other and necessary for the pro appropriate care to al needed, to include the availability of a register	ensed practical cillary personnel vision of I patients, as e immediate				
	facility failed to ensur- licensed and unlicens to meet the needs of	t as evidenced by: review and interview, the e adequate numbers of sed personnel were available patients for 2 of 2 patient t B4) and 8 of 10 patients				

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	· '	(X3) DATE SURVEY COMPLETED		
						С
		005051	B. WING	· · · · · · · · · · · · · · · · · · ·	02	2/24/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
INDIANA	IINIVEDOITY HEALTH	1701 N S	ENATE BLVD			
INDIANA	UNIVERSITY HEALTH	INDIANA	POLIS, IN 46202			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S 926	Continued From page	± 1	S 926			
	medical records revie 8, 9 and 10).	wed (patients #1, 2, 4,6, 7,				
	Findings include:					
	OF PATIENT CARE A effective date of 4/13 Each patient service of formalized staffing pla annually" The st for an RN (registered and a CPCA (certified 1:12. The staffing pla RN:patient ratio of 1:4 of 1:8-12 patients. 2. Facility policy titled Administration Times indicates in appendix administration times of and 2100 hours and effective formalization times of an accordance of the formalization times of t	d "PLAN FOR PROVISION AND SERVICES" with an states on page 7 of 10: "3. department maintains a an which is reviewed at least affing plan for unit B4 calls nurse):patient ratio of 1:3 d patient care associate) of an for unit B7 calls for an d and a CPCA:patient ratio d "Standard Medication of twice daily is 0900 hours devery 12 hour medications good hours and 2100 hours.				
	3. Facility policy titled STANDARDS: INPAT of 10/12 states on para. Record temperaturate, and blood press "C. DAILY ASSESSA STANDARDS 1. Vitarecords as ordered"18. Narrative Notes whenever the electrosupport the level doctaccurately and adequevent, situation or carmain types of narrativ Clinical NotesClin	d "DOCUMENTATION FIENT" with an effective date ge 3 of 15: "4. Vital Signs re, heart rate, respiratory ure." Page 6 of 15 states:				

Indiana State Department of Health

STATE FORM P1LU11 If continuation sheet 2 of 11

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		7 20.22				
	005051	B. WING		02	C 2/24/2015	
PLIER	STREET AD	DDRESS, CITY, STAT	TE, ZIP CODE			
	1701 N SI	ENATE BLVD				
ALTH			!			
MMARY STATE		· ·		F CORRECTION	(X5)	
DEFICIENCY N	JUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	COMPLETE DATE	
om page 2	2	S 926				
ng care'sment and s, as order onditions in nas a spec	' Page 14 of 15 states Care Standards Timeline ed, 4. Pt position if one s met (patient is immobile, ific position ordered or a					
2/14 and 2 t the unit way plan. The charge nure 24 patients in night shirts and the constant was short 12/1/14 the consus was short 15/14 the consus was RN and 1 to census was ech on night 22 patients was short 12/1/14 the consus was short 12/1/14 the consus was short 12/1/14 the consus was short 13/1/14 the consus was RN and 1 to census was ech on night 22 patients	2/15/15 through 2/23/15 2/24 as not staffed according 2/25/14 the and the unit was short 2/25/15 the census 2/25/25 the census 2/25/25 the census 2/25/25 the census 2/25/25 the census 2/25/25/25 the census 2/25/25/25 the census 2/25/25/25 the census 2/25/25/25 the census 2/25/25/25/25 the census 2/25/25/25/25 the census 2/25/25/25/25/25/25/25/25/25/25/25/25/25					
TIC TO THE FOREST CONTRACTOR OF THE STATE OF	rom page 2 tient's care ng care' sment and s, as order conditions is has a spec r for chang f staffing fo 0/14 and 2 t the unit w g plan. The charge nur 24 patients on night shir nts and the s (there wer 0n 12/9/14 the unit was 11/14 the or was short 1 ch on night 24 patients shift. On 1 ind the unit 15/14 the or was short 1 census wa RN and 1 te census wa RN and 1 te census wa RN and 1 te census wa census wa sech on nig 22 patients shift. On 2	005051 PLIER STREET AD 1701 N SI	PLIER STREET ADDRESS, CITY, STATEBLTH MMARY STATEMENT OF DEFICIENCIES INDIANAPOLIS, IN 46202 MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL STORY OR LSC IDENTIFYING INFORMATION) Tom page 2 tient's care. r. Inability to performing care	PLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202 MINIMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) TOM page 2 tient's care. r. Inability to perform ng care	PLIER STREET ADDRESS, CITY, STATE, ZIP CODE ### STREET ADDRESS, CITY, STATE, ZIP CODE ### ALTH INDIANAPOLIS, IN 4622 ### AL	

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			_			
		005051	B. WING		02	C 2 /24/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		1701 N S	ENATE BLVD			
INDIANA	UNIVERSITY HEALTH	INDIANA	POLIS, IN 46202	2		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE
S 926	Continued From page	2 3	S 926			
	the census was 23 na	atients and the unit was				
		ift and 2 techs on night shift				
		working), On 2/17/15 the				
	· ·	its and the unit was short 1				
	-	2/21/15 the census was 18				
	_	was short 1 tech on night				
	-	census was 21 patients and				
	the unit was short 1 to					
		as 23 patients and the unit				
	was short 1 RN and 1	tech on night shift.				
	5. Review of staffing	for unit B4 for 12/21/14				
	through 12/27/14 and	2/15/15 through 2/23/15				
	indicated the unit was	not staffed according to the				
	staffing plan. On 12/2	21/14 the census was 24				
	patients and the unit	was short 1 RN on day shift				
	and 1 RN and 1 tech	on night shift. On 12/22/14				
	· ·	atients and the unit was				
		ift. On 12/23/14 the census				
		he unit was short 1 RN on				
		and 1 tech on night shift. On				
		was 16 patients and the unit				
		ight shift. On 12/25/14 the				
	-	its and the unit was short 1				
		n 12/26/14 the census was nit was short 1 tech on day				
		On 12/27/14 the census was				
		nit was short 1 RN and 1				
		n 2/15/15 the census was				
	_	nit was short 2 RNs on day				
		tech on night shift. On				
		as 23 patients and the unit				
		syshift and 1 RN and 1 tech				
		7/15 the census was 20				
	_	was short 1 tech on night				
	•	census was 18 patients and				
		RN on day shift and 1 tech on				
	night shift. On 2/20/1	•				
	_	was short 2 techs on night				
	⁻	echs working). On 2/22/15				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _					
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		005051	B. WING		02/	24/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
ΙΝΠΙΑΝΑΙ	JNIVERSITY HEALTH	1701 N SE	NATE BLVD				
INDIANA	JAIVERSIII IIEAEIII	INDIANAF	POLIS, IN 46202	2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
S 926	Continued From page	e 4	S 926				
	the census was 22 patients and the unit was short 1 RN on day shift. On 2/23/15 the census was 21 patients and the unit was short 2 techs on night shift (there were no techs working).						
	the following: (A) An order was wri 12/7/14 for Heparin 5 every 12 hours. Per policy, administration and 2100 hours for at the medication admin Heparin was not adm 12/7/14. 7. Review of patient the following: (A) An order was wri 12/11/14 for Torsemic daily. The MAR lacke	#2 medical record indicated tten at 1700 hours on de (diuretic) 80 mg twice ed documentation three would be 0900 hours on every 12 hour order. Per nistration record (MAR), the ninistered until 2334 hours on					
	(B) An order was write 12/12/14 for Troponing which was not drawn was discovered on 12 Troponin was drawn aresult of .05 (normal result of .05 (normal result)) and an orden neurochecks every 2 flowsheet review, the performed per order. conducted from 12:00 from 1600 hours to 20 hours to midnight on were not conducted fip.m. on 12/22/14, not	n (lab test) every 8 hours x 2 . Per nurses notes, the error 2/13/14 at 0409 a.m. and the at 0627 on 12/13/14 with range <.03). transferred to unit B4 on er was written to do hours. Per nursing neurochecks were not The neurochecks were not 0-1600 hours on 12/21/14, 000 hours, and from 2000 12/21/14. The neurochecks rom 0400 hours to 12:30 at conducted from 1342 hours 22/14, and not from 2000					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X3) DATE SURVEY COMPLETED		
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		005051	B. WING		02/24/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E. ZIP CODE	
			ENATE BLVD	-,:	
INDIANA	UNIVERSITY HEALTH		POLIS, IN 46202		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
S 926	Continued From page	÷ 5	S 926		
	hours to 0800 hours of	t conducted from 0400 on 12/23/14, and from 0800 on 12/23/14, and from 12:00 n 12/23/14.			
	the following: (A) An order was write 2/22/15 for neuroched signs every 4 hours. (B) An order was write bedrest. (C) The medical receive that the neurochecks Per flowsheet docume were not conducted from 2/23/15 and from 0 2/24/15. (D) The medical receive that the vital signs we flowsheet documenta	tten at 2233 on 2/22/15 for ord lacked documentation were conducted per order. entation, the neurochecks from 0900 hours-1700 hours 0100 hours-0700 hours on ord lacked documentation are obtained per order. Per tion, the vital signs were not			
	were not taken from 0 2/23/15 and were not 1700 hours on 2/23/1 (E) The medical recording that the patient was to policy. Per nursing fluor turned from 2300 2/22/15-2/23/15, was until 0700 hours on 2/1100 hours until 1500	rs to 0742 hours on 2/23/15, 1742 hours to 1107 hours on taken from 1107 hours to 5. Ford lacked documentation urned every 2 hours per towsheets, the patient was hours until 0300 hours on not turned from 0300 hours (23/15, was not turned from 1 hours on 2/23/15, was not ars until 2300 hours on			
	(F) The medical reco	#6 medical record indicated			

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
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		005051	B. WING		02/24/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
INIDIANIA	ININGEDOLEN LIE AL TIL	1701 N SE	NATE BLVD			
INDIANA	UNIVERSITY HEALTH	INDIANAF	POLIS, IN 46202			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
S 926	record lacked docume were taken per order. the vital signs were not 1700 hours on 2/18/1 1700 hours to 2203 o not taken from 2203 h 2/18/15-2/19/15 and taken from 0326 to 08 10. Review of patient indicated the following (A) An order was writ 2/19/15 to call M.D. w (SBP) > 160 or < 90. B7) (B) An order was writ 2/21/15 for Labetalol prn for SBP > 180. Ton 2/23/15 and an ord 2/23/15 for Labetol 10 diastolic blood pressurursing flowsheets, the was 201/123 at 0830 at 2120 hours on 2/21 on 2/21/15, 171/100 at 173/100 at 2300 hour 0200 hours on 2/23/1 2/23/15, and 175/110 Per record review, the were not reported to the Additionally, the blood	every 4 hours. The medical entation that the vital signs Per nursing flowsheets, of taken from 1200 noon to 5, vitals were not taken from n 2/18/15, and vitals were nours to 0326 hours on the vitals signs were not 844 hours on 2/19/15. If #7 medical record is ten at 0744 hours on eith systolic blood pressure (order still current on unit ten at 0816 hours on 10 mg. I.V. every 4 hours this order was discontinued in written at 1334 on 10 mg. I.V. for SBP > 170 or 10 mg. for III mg. for I	S 926	DELIGITION TO THE PROPERTY OF		
	11. Review of patient the following: (A) An order was writ vital signs every 4 hor	#8 medical record indicated tten at 1549 on 2/19/15 for urs. Per flowsheet review, re not taken from 0300				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BOILDING.		С
		005051	B. WING		02/24/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ΙΝΟΙΔΝΑ Ι	JNIVERSITY HEALTH	1701 N SE	NATE BLVD		
	SHIVEROTT TIEAETT	INDIANAF	POLIS, IN 46202	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE
	from 1500 hours to 20 not taken from 2000 h 2/20/15-2/21/15, were to 0819 hours on 2/23 from 0200 hours to 1.2. Review of patient indicated the following (A) An order was write 2/20/15 to report SBF 50. (B) An order was write 2/20/15 for vital signs signs were not taken	t #9 medical record g: tten at 1338 hours on P > 180 or DBP > 100 or <			
	0400 hours to 0800 h taken from 0400 hour Additionally, the patie 136/105 at 0800 hour medical record lacked physician was notified 13. Review of patient indicated the following (A) An order was writ 2/20/15 for vital signs	ours on 2/21/15 and not is to 0805 hours on 2/24/15. Into blood pressure was is on 2/22/15 and the id documentation that the id per order. If #10 medical record is it is at 12:09 p.m. on every 2 hours and an order			
	M.D. if DBP < 50. Pe signs were not taken were not taken from 1 2/21/15 and were not 2200 hours on 2/22/1 blood pressure of 117 2/21/15, 118/48 at mid 1500 hours on 2/22/1	dnight 2/21/15, 125/48 at 5, and 110/45 at 2200 hours eported to the physician per			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7.1.13 . 2.1.1		IDENTIFICATION NOMBER.				
		005051	B. WING		C 02/24/201	5
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
INDIANA U	JNIVERSITY HEALTH	1701 N SEN				
			OLIS, IN 46202			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CON	X5) MPLETE NATE
S 926	Continued From page	e 8	S 926			
	assisted with and ver	ified the medical record at 1:00 p.m. on 2/23/15.				
	Specialist) verified in	(Accreditation Regulatory interview beginning at 11:40 he staffing plans presented ing plans.				
	indicated in interview 2/24/15 that ideally th have a patient assign the unit has remained He/she verified the st	(Clinical Manager of B7) beginning at 9:15 a.m. on e charge nurse would not ment. He/she indicated that I full for the last 2 years. affing sheets completed the staffing was less than ills for.				
	interview beginning a the unit is typically sh and unlicensed staff a has contributed to an indicated the unit has lots of medications ar care. He/she indicate	(RN unit B7) indicated in t 9:50 a.m. on 2/24/15 that ort staffed with both licensed and feels the staffing levels increase in falls. He/she heavy care patients with ad patients that are total ed that at times medications due to staffing issues.				
	interview beginning a they try to schedule the pattern, however staff other units. There had toward the end of 201 and he/she feels that difference in the fall ramedications are giver feels staffing is an iss	0 (RN unit B7) indicated in to 10:00 a.m. on 2/24/15 that the unit according to the former get floated to so been an increase in falls 14 and beginning of 2015 staffing levels has made a lates. He/she indicated that in late due to staffing and ue on the unit. He/she feels do to the side and is not as				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or doring of the state of the s	IDENTIFICATION NOWIDER.	A. BUILDING: _		
		005051	B. WING		C 02/24/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
INDIANA I	JNIVERSITY HEALTH		ENATE BLVD POLIS, IN 46202	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
S 926	at 10:30 a.m. on 2/24 has total care patients times if there are only patients are a heavy I patients and turn patients can't go bathed because there 20. Staff member #8 interview beginning a approximately 50% of patient assignment with He/she indicated that patients, "things that I and sometimes talkin rushed. 21. Staff member #1 interview beginning a he/she has 5 patients this unit. He/she indicated that unit a lots of medications et 22. Staff member #1 interview beginning a usually there are 2 PC occasionally there are for the care of twelve indicated that at times baths completed or parepositioned. He/she patients take priority for 23. Staff member #1	(PCA [patient care licated in interview beginning /15 that the unit frequently so. He/she indicated that at reference 2 techs on the unit and load that it is difficult to clean ents and there are times et turned every 2 hours and eare only 2 techs. (RN unit B7) indicated in the time he/she has a hen he/she is charge nurse. When he/she has had 5 have to be done are done go to patients or teaching is 1 (RN unit B7) indicated in the time he/she has had 5 have to be done are done go to patients or teaching is 1 (RN unit B7) indicated in the time he/she indicated that the reference patients with contact that the work gets are heavy care patients with contact that the reference patients with contact that the responsible (12) patients today. He/she is he/she is not able to get attents turned and indicated that incontinent	S 926		
		there are six (6) nursing			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
					С	
	005051	B. WING		02	/24/2015	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE			
INDIANA UNIVERSITY HEALTH		ENATE BLVD POLIS, IN 46202	!			
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
usually has 1-3 techs of that medications are gitime. 25. Staff member #16 Chief Nursing Officer (6)	Additionally, the unit ad vacancies since indicated in interview on 2/24/15 that the unit on duty. He/she indicated ven but may not be on (Vice President (VP) and CNO) verified in interview on 2/24/15 that he/she is	S 926				

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